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ABSTRACT

Because physicians are perceived as powerful and knowledgeable professionals, the language they use to address patients has a tremendous effect on a patient's mental and physical well-being. Physicians often speak to patients in "med-speak," obscure, highly technical terms that cloak the reality of the patient's condition and serve to reinforce the "inferior/superior" dynamic between patient and physician, and patients are often reluctant to ask physicians to clarify what they mean, for fear of being labeled ignorant and inferior. Physicians often view patients as having little or no knowledge of their own conditions that would help in a diagnosis or treatment, and having little capability to understand their conditions. Hence physicians converse with and listen to patients as little as possible. To reduce the distance between doctors and patients, medical schools must teach medical students (1) to look at patients as suffering humans rather than bodies housing disease, (2) to listen to patients carefully and make sure that patients understand what is said to them, and (3) to understand that the objective language of medicine cannot be objective when it is used to communicate with nonscientists. Patients must demand information from their physicians that is understandable. (Nine references are included.) (JC)

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THE LANGUAGE OF MEDICINE: THE ETHICS OF OBSCURITY

For the past ten years, I have worked at a University centered around an internationally renowned medical center. During this time, I have taught and tutored a number of students who plan to make medicine their careers, students ranging from those enrolled in pre-nursing and medical technology programs to post-docs serving as interns and residents. The writing of beginning students, of course, mirrors the concerns found in all students who first concentrate on specific careers: mastering the mechanics of language, acquiring an appropriate vocabulary, and developing an uncluttered syntax. The language of the advanced pre-medical students, however, focuses on very different criteria. They are concerned with the effect of their language--both written and oral-- on the various audiences, the patients and their families, their peers, their professors, to whom it is directed; in short, they want to deal with rhetoric in the classical sense, in its purest form. The complexity of language used by these students at various stages of career development reveals a linear progression. At the lowest level they are concerned with accurate observation expressed with precision and clarity. As they advance, their observation is used as the basis of drawing conclusions, formulating diagnoses, and postulating hypotheses. During the earlier stages, their audience is generally limited to clinical professors who are less concerned with the students' style of writing than with their grasp of factual material and their powers of observation. The

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language of the graduate students, though, reveals a marked change; these students use language to manipulate their patients' habits of thought, to initiate or prevent courses of action. The post-docs quickly learn they have the power to profoundly affect the lives and wellbeing of the patients through their use of language. Obscurity allows the speaker to place whatever meaning he desires on language. Carried further, physicans have the ability to shape society to conform to their preconceived notions of what it should be, to decide, in effect, whom it should be peopled with. The use or abuse of this language of medicine, not only the verbalization but also the consonance and dissonance between verbal and non-verbal language, the dress, gestures, and tone which serve to reinforce or negate the actual messages being delivered, is an issue which is dealt with in a number of medical ethics courses and is now being addressed in the literature of rhetoric, although it is still largely ignored by the very society it permeates and seeks to mold.

In its larger sense, the use of the language of medicine, the ethics of obscurity, is most popularly associated with three aspects of our society--financial implications, legal adjudication, and medical research--all language interactions the physician faces, between peers, among colleagues, and in the public forum. However, the crux of the problem is both more personal and basic: it concerns itself with the immediate relationship between the physician and the patient.

To understand the ethical implications of the language use between physicians and patients, two separate issues must be considered. First, the term ethics itself must be clarified. When dealing with the physician-patient relationship, ethics is considered both in the classical manner, that is the "ethos" as outlined by Aristotle and in the more modern usage which connotes a

moral issue, an action in accordance with the principles of right and wrong governing the conduct of a group. Every physician swears fealty to an "ethical professional behavior" with the administration of the Hippocratic Oath. In truth, this fealty is directed toward protecting the profession and practioners at the expense of the patient when a conflict between the two arises. The ethics of the profession in practice may bear little semblance to the more commonly understood use of the word. Each usage, however, profoundly affects the physician-patient relationship.

Furthermore, the act of communication itself must be considered, particularly the goals, the expectations, and the effects. Not only the language itself, the words which are the popular coinage, but also the manner of presentation determines the effectiveness of the physician-patient relationship. The act predicts the outcome.

Finally, the result itself is crucial. What a physician does or does not say, why he chooses to act or be inactive, whether he touches or avoids the patient, how the patient responds all rely to a great extent on the language used and manner of presentation. This individual response, while important on its own merit, further mirrors the response of society at large and its perception of and reaction to the language of medicine.

The physician's language, necessarily, changes according to the age and mental acumen of the patient. For instance, the physician rarely speaks to a child, and this reluctance to speak tells volumes. Like the child, the geriatric patient fails to receive direct communication. These people are spoken about, but not spoken to. The terminal patient, because he represents an affront to the physician's skill, receives even less personal interaction than either the young or old. It is, however, doubtful that the physician's manner,

goals, or perceptions undergo a conscious change. His language use is reactive, an indication of the role he has been taught he should be playing, a lesson he has learned well. For brevity when considering this complicated topic, only one aspect of the language use will be targeted: communication between the physician and the sentient adult.

Ethos in the classical manner meant using the ego, the authority of the speaker, to persuade others to produce certain action. To fully appreciate how this subject affects physicians, several variables of the rhetorical situation must be considered. These variables include the role of the rhetor, the audience, the occasion, and the style of the communication. These last three variables are directly controlled by the first, the perceived role of the physician.

The very term used to refer to physicians connotes a mystical quality. A "physician" originally meant a moral or spiritual healer, whereas the term "doctor" meant a teacher who had a right by virtue of his knowledge to express an authoritative opinion. Medicine itself referred to healing, godliness, magic. The physical examination--the laying on of hands--reflects this magical aspect. The physician's role has always incorporated this spiritual and magical quality. Socially, these qualities have set him apart from the rest of mankind, put him in a position of possessing unique knowledge and ability which will be dispensed only after supplication by those who need it. It is no coincidence that medical schools and medical practioners perpetuate this distinction of titles. While laypeople commonly use the term "doctor," members of the profession invariably use the term "physician" to describe themselves. Furthermore, "doctoring" is not what they do; they practice medicine. This terminology is drummed into their heads during their medical education and later

reinforced by their colleagues.

The term "patient," on the other hand, originally meant a sufferer in need of repentance, one who was morally depraved. The disease, lack of comfort, exhibited by these people, was often considered just punishment for some unnamed sin. The physician's job was to rid the patient of his discomfort by determining the cause of the problem and prescribing a change in lifestyle which would eliminate the disease. If all of this smacks of shamanism, it is no coincidence. Physicians, as we know them, practice the same medicine worldwide.

While the traditional role of the physician was to identify the problem, treat the symptoms, and affect a cure for the patient, the patient himself was often seen as a reluctant participant in this process, one who refused to cooperate, who withheld crucial information, who was reluctant to change his actions. This reluctance was thought to stem from two causes: fear of learning what was wrong and fear of being judged morally inferior. The patient was seen as a depraved person incapable of improving his condition without the help of the physician. Restoration to physical health was an indication of an improved spiritual condition. Thus, the very act of submitting one's health, and by extention one's spiritual wellbeing, to the physician underscored the hierarchy of authority that existed between the two groups. It is little wonder that the perceived roles of the two people involved in this transaction served to alienate the two groups.

This dichotomy of roles, the superior and inferior, continues today. Physicians, while not necessarily seen as spiritual guides in our culture, are nevertheless seen as professional and social leaders of the community, as people holding knowledge and power crucial to judge the quality and affect the lives of others. They determine not only how we live, but at times the very issue of

whether or not we live at all.

As patients, we still see ourselves as inferior to the physician, as people who have lost control of our lives and must abdicate our health care to another. Most patients have neither the ability to diagnose the problem nor the skill to rectify the wrong. Even if we had this ability, we have no power to act. Legally we are denied the authority to practice medicine, to prescribe drugs. At times we are even denied the right to choose how we will or will not be cared for, the right to live or to die. As patients, then, we still find ourselves in an adversarial relationship with our physicians, often refusing to cooperate because of fear: fear of being judged ignorant or depraved by those we sense are our superiors, and fear of losing what little control we may have of our lives.

Physicians are well aware of the patients' lack of cooperation and interpret it as a challenge to their authority, their superior knowledge. This fosters contention between the two groups, an autocratic attitude which expresses itself with predictable language use. The physician distances himself from the patient, refusing to develop a relationship of mutual cooperation, choosing instead to issue orders which are then left to the patient or his immediate caregivers to follow. This distancing reinforces the superior/inferior hierarchy of the physician and patient.

The language, verbal and non-verbal, the physician uses to and about his patient--med-speak--is the most obvious indication of the perceived difference in status and perception of the problem. The physician receives patients at his convenience, often not greeting them even the first time they meet, failing to introduce himself, and assuming that he is known. Pertinent information about the patient has already been gathered by those hired to screen the physician

from unwanted or needless interruption. Often the patient is undressed when he and physician first meet while the physician is dressed in a suit and tie, cloaked in the white coat of authority. The physician is formally referred to by both a title and surname although the patient is commonly called by his given name, regardless of any age difference which may exist between the two. The physician generally stands during the interview and examination while the patient is either seated or reclining. These differences underscore the contrasting public status between the two individuals, but the attitude toward the relationship is even more profound. Physicians are taught to focus on disease, abnormalities from wellbeing, while patients are concerned with illness, what it means to be sick. The physician is seen as a social and intellectual superior who has access to a needed commodity. The patient is seen as a body which houses disease, not as a fellow human who may be suffering. So, from the start, the physician and patient are at odds: they have assumed an hierarchial status and they are concerned about two different aspects of the problem, only tangientally related.

Somehow, communication must span these vastly divergent attitudes. Even though communication may be more crucial to the practice of medicine than to many other professions, nearly every patient reports a high degree of unsatisfactory verbal interaction with his physician. The physician's distinction between patient and person, perhaps a necessary attitude assumed to preserve the emotional stability of physicians who constantly encounter trauma, results in situations all of us have known: the man struggling for his life in a glass cubical is referred to as the "renal failure in ICU"; the depressed woman recently admitted is charted as a "LOLINAD, little old lady in no apparent distress"; the diagnosis for the indigent patient in the emergency room becomes

a "GOMER, get out of my emergency room." In each of these cases, the physician sees a patient, not a person, a case to be dealt with as efficiently as possible.

Efficiency in dealing with a patient is a skill emphasized in medical school and reinforced during on the job training by grand rounds conducted by senior staff members who serve as role models. For the physician, it means using critical listening skills, screening information while making judgments, getting accurate information as quickly as possible, ignoring interpersonal relationships, and avoiding empathetic listening, that is withholding judgment until the whole story is told. Information is most credible if it results from direct observation, less helpful is gained from the conclusions of other, least believable if offered by the patient. Physicians rely on scientific terminology to describe symptoms and disease with objectivity, terms not readily understood by those without medical training. Physicians observe that patients ambulate, visualize, articulate, and masticate while patients believe that they walk, see, talk, and chew. Physicians don't seem to realize that patients often do not have the vaguest notion about what these terms mean even though they are crucial to effective communication. In an attempt to fill in the communication gap, patients may substitute vague or inaccurate definitions for the uncommon vocabulary. Physicians used to dealing with the precision of scientific language sometimes assume this vagueness to be an indication of reticence, ignorance, or a ploy for attention, an annoying waste of time. This results in further limiting the personal interaction between physician and patient. A recent study observed that patients have an average of 16 seconds to communicate their problems to their physicians before being interrupted. The physician in turn responds with specific, leading questions which tend to restrict the

informational response rather than allow the patient to describe the problems he has although many studies suggest that given the opportunity, patients often are able to pinpoint exact symptoms which effectively diagnose their problems. Nevertheless, the patient is rushed through the interview by the physicians who has been taught that communication is a one-way channel which must focus on one issue. Anything which seems irrelevant is perceived as a waste of the physican's valuable time. Furthermore, physicians rarely check to learn if the patient has understood what has been said. Nor do they routinely summarize their statements or attempt to organize them in a manner which is easily comprehensible to a listener. Physicians' conclusions are self-directed, either unstated or presented in an associative or linear rather than logical manner. One study estimates that 95% of the physicians refused to ask whether or not the patients had understood what was said. This, of course, indicates that the poor communication is a consciously adapted stance, not a random practice of a few insensitive physicians. Those who are concerned with patients understanding are the exception rather than the rule. With disparate languages being used by physician and patient, meaning cannot be conveyed, it must be created. Obviously this is not happening in the physician/patient relationship. For the patient, this misunderstanding complicates diagnosis and undermines treatment as well as reinforces the perceived dichotomy between the two parties.

For the physician, this miscommunication is financally as well as professionally costly. Patients, frustrated by the lack of information about the dangers of procedures or with physician's lack of clear communication, are venting their anger in the courts and finding sympathetic jurors who support their claims of malpractice or "bad medicine." In medical disputes arising from misunderstandings, courts have consistently ruled that the responsibility for

clear communication belongs to the physician, not to the patient. Currently, about half the malpractice suits relate to informed consent problems. This crisis highlights the problem, but does little to resolve it. On the one hand, it further alienates physicians and patients, making physicians even more cautious about their language, causing them to retreat further into the maze of scientific terminology which may convey precise meaning but limited communication. This defensive attitude, of course, only exascerbates the problem. At the same time, the patient learns even less about his condition and feels little compunction about bringing suit against the remote figure in charge of his case. Until medical schools recognize this dilemma and counter it by changing physicians' attitudes, this communication gap will continue to be adjudicated in the courts.

Unfortunately, patients themselves help perpetuate this cycle of miscommunication. Too many have accepted the traditional attitude that the physician's time is more valuable than theirs, his knowledge is superior, his diagnostic skills somehow are unrelated to the information they have about their own cases. They are reluctant to display ignorance and have their inferiority confirmed. When questioned, these patients equate the perfunctory physician with one of superior skill and are suspicious of those who seem to rely on the patients for information. Diagnostic skill and practical results are praised while the inability to communicate effectively is tolerated by both the profession and the public. This attitude, of course, perpetates the system of miscommunication and reinforces the use of traditional models adopted by medical schools.

In our culture, this lack of intelligible communication is reeking havoc between the medical profession and the public. Changing the attitudes of both

physicians and patients will be difficult, but it is necessary if we hope to peacefully co-exist. As technology becomes more complex, decisions which affect the quality of our individual as well as collective lives must be shared. How much deformity will be accepted, how much illness will be tolerated by the elderly, who receives the organ transplantation, what direction will genetic engineering take, who decides when the machines should be disconnected are questions which cannot be left to the physician alone. The demographics of who will people our society is a decision all of us must determine, not just a group who is systematically taught to separate logic from emotion, to see a person as a damaged vessel rather than as a suffering human. All those who live in society, who pay the bills, who give the needed on-going care, who share space with the maimed and old and retarded and sick are the ones who must ultimately decide how much we are able to handle.

We have to understand that sensible decisions result from understanding, understanding which comes from clear communication, communication which creates meaning. Physicians and patients both must share the responsibility for the current state of failed communication. Physicians must understand that while the scientific language of medicine strives to be objective, it can never be objective when used to communicate with non-scientists. Patients must learn to demand answers to medical questions in a language they can understand, not to be intimidated by the vocabulary, status, and education of those who treat them. Language must be considered in relation to both the speaker and the listener, the ethos as well as the pathos. As it is now used, the language of medicine is unethical. It is unethical classically because the perceived authority of the physician, both inside and outside of the profession, is skewed, based on a false premise of who the person is, of his importance and moral worth because of

his specialized knowledge. While the physician may have specialized knowledge about the field of medicine, it does not necessarily follow that the physician is more intelligent, moral, or capable of making rational decisions than are his patients. The language of medicine is unethical contemporarily because it violates the basis of moral decision making, the consideration of a group concensus of established standards to determine right and wrong. Rather, the language of medicine as it is currently used ignores the beliefs and wishes of those to whom it is directed. It is manipuative, designed to enhance the self esteem of the physician, to control the destiny of the patient, and ultimately to shape society to conform to the ideal of the physician. In the more profound sense, the language of medicine is immoral; while it purports to serve a "higher good," it does so without considering the individuals which make up that very society. The "higher good" served by the physician is whatever he chooses it to be, regardless of the consequences. The reality which results from his choice is rarely one which affects him personally. He is not the one who for years physically, financially, and emotionaly cares for the profoundly brain damaged child whom he heroically saved. By ignoring the good of the individual, the physician necessarily ignores the greater good of society.

Communication is a learned behavior which involves incorporating nuances outside our own awareness, learning from interacting socially with friends, family, and role models, and formal instruction about theory and practice. These skills must be incorporated into the medical education of physicians and reinforced by those who serve as role models if we are to see significant changes in the use of the language of medicine, if we want to be able to consider the language of medicine ethical.

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